terrified out of their fucking minds by the French so-called Revolution.

Perhaps it makes the difference if you make it explicit or not?

Marx is a fall-out of that. I mean he is a lawyer, very bourgeois sort of character. I don't think he had any working class friends.

But would you agree that what he did was to make explicit what had previously necessarily been covered up? I mean there aren't many politicians that would go around admitting that primarily what they are are the executives of the bourgeoisie!

Yes, they admit that to themselves..

They admit it to themselves, but not publicly!

Oh, no, you don't want to admit these things publicly..

Of course not, otherwise it would break down.

Lenin went around with Machievelli..he had Machievelli under his pillow - on what it means to be a politician, what power means, how to lie and deceive,etc. Truth doesn't come into it. Stalin said: If you imagine that truth has got anything to do with politics you have to imagine the sky is made of wood.

Well, that's a very cynical viewpoint. Would you say that's why the Russian Revolution failed? OK, is that why Marxism, as opposed to Marx, has been a failure?

Apart from the practical, real Marxist politicians, like

Lenin, Trotsky and others, most Marxists are sort of marginal sociologists at the LSE and Sussex and this sort of thing who are /TAPE SIDE ENDS/

What you seem to be saying is that politicians lie and that seems to be the case because they have absolute power, and absolute power corrupts absolutely. Would you agree with that?

No,they haven't got absolute power. They are a component in a very complex system of power. Multinational companies have got their own foreign policies that are not necessarily those of the particular upfront politicians in a local territory in the world.

Right, but any politician..

..has not got absolute power.

Right. But is bound to the multinational companies, ultimately, then. Society is then dictated to by those companies..

No, wait a minute. You can't sort of collapse into: power lies with the multinational companies. Power is distributed between all sorts of different sections, classes, interest groups, all contending for power. And the resultant decisions arise out of a power struggle. Not just the simple struggle between the working class and the capitalist class.

Right. There's also a power struggle between the power groups themselves, and would you see one of those..

Yeah. There's an Arab prince just now who's up for trial in London for dealing in cocaine...

I don't know about that. But would you agree that one of those power groups are psychiatrists, the psychiatric establishment, for want of a better term? Would you agree that they are one of those powerful groups?

Yeah.

And how do you feel about the amount of power that is vested within the psychiatrist?

Far too much. Far more than a judge. A judge can't sentence someone to an indefinite sentence, as a psychiatrist can. Which permits someone to strip them of civil liberties even a condemned murderer retains.

Do you think, then, that there should be more democracy in psychiatry?

There should be more of a distribution of power. See, one of the things the Italians have tried to do,the ultimate decision, if anyone was going to be put away, had to be underwritten by the local politician, not the psychiatrist. Because it was a political decision to decide if anyone was going to be picked off and taken away and put away and kept away, because they're a nuisance, because he is a nuisance, an encumbrance to other people. That is not a medical decision, it's a political decision. Now that is a clarification of that.

Also, as I understand it, the Democratic Psychiatry group in Italy has quite explicitly worked towards a sharing of power, and sees that as one of the most fundamental issues in psychiatry.

I agree. Absolutely, absolutely.

Can you say how you think that might come about in this country in psychiatry, power-sharing? Can you see it happening? If so, how?

It is happening. And it'll happen more. Of course, the technique of dealing with this sort of problem that psychiatry is faced with, of somehow or other putting people out of sight and out of mind, is not working now because there are too many people. It's permeable through all social classes. It affects young and old and men and women and wives and husbands.. I hear of a professor of psychiatry who comes to another psychiatrist about his nineteen-year-old daughter who's sort of a bit excessive. And he lives in another part of the country and his daughter comes to London. So she is about to be put in psychiatric care and possibly given electric shock. And he approaches this psychiatrist in public and says: "Oh, Doctor, I've got a daughter, er, but I don't want this to happen to my daughter." You know? "Can you think of some other way of dealing with this situation?"

/reads from notes/ In the mid- to late- '60s, when you were associated with Cooper, at the time of The Politics of Experience and of the Dialectics of Liberation Conference that you helped to organise, you appeared to have reached your most radical position. Your view seemed the most expressive of the experience of loss of reason and of the politics of scapegoating that drives people mad. At that time you expressed the unqualified idea that, in a world gone mad, (specifically with reference to the role of imperialism in South East Asia), the supposedly irrational expressions of those we normals consider mad were, by double negation, actually saner than the normals' worldviews. That the mad, were we to listen, expressed, perhaps disjointedly and elliptically, the truth about social reality. Whereas we normals were all living a Big Lie. This took you right up to the edge of a global, radically Marxist critique of our culture, and hence the role of madness within it, of the necessity

of madnesses' various forms, of the necessity of the persecution of visionaries, seers, etc. But you never seemed to have developed this, but rather to have stepped back from such a global critique.

Now, this places your work in the same boat as any other partial, piecemeal view and therapy of bourgeois psychiatry - making it as possibly true as other viewpoints, but also as possibly untrue. Failing to encompass all other views, and criticise them systematically, your viewpoint is neutralised: becomes just another flavour in the array of bourgeois techniques, and even becomes co-opted by imperialism as an example of its own toleration: "Look, we offer the greatest array of techniques, from fascist lobotomy and shock treatment and behavioural modification to radical Laingianism. See what freedom capitalism offers."

But if all are equally valid, all are equally invalid theories and techniques.

Sorry that was so long, but could you comment on that?

greatest intelligent impact on 20th century thought and action. And I'd like to ask you why, in the past - perhaps you've already answered this, in a sense - why you haven't systematically written about Freud, about Marx? And how do they, in fact, relate to your ideas? Are you, for instance concerned with Freud's ideas on sexuality?

Oh, yeah, um. I think he's wrong about practically everything he wrote about, in terms of sexuality, in a sense. But he's tremendously important because he addressed himself to these issues. Although I think he got it all upside down and twisted around. So it's a very complicated argument, it's not that..I mean, if there's anyone that I read more of and thought about, in terms of the 20th century, apart from Marx,it's Freud. Just for that reason, however, I'm very sensitive to the ambiguities and complexities of addressing that Freudian question. I haven't written about it so far. I hope I shall. But I'd reserve this for the latter part of my life, if I live long enough.

Well, unfortunately that paragraph is only too true. I could cavil at some of your expressions in that paragraph. Basically I realised in the late '60s and early '70s that the response of society to incorporate and assimilate the radical critique of itself that I was trying to develop, and so on, was checked by countermoves. So, since then, I haven't given up any, at all, from then, but I've gone into deep thought about that. Ten or fifteen years is nothing, a tiny...while things were sort of going on anyway.

And, also, that I realised that my theoretical relationship, the thing in terms of so-called Marxism: Marxism has got to update itself from 1880 to 1986, post-1984. That, in fact, I was tremendously ignorant. I'm less ignorant now than I was then about the contemporary world of post-industrial multinational capitalism.

And you can tell me if there is any contemporary mind or nest of minds, if you want to call it, in the Marxist tradition, who have really got a grip on the present socio-economic infrastructure of powers, in the world. I realise that the whole mass of feminist critique of the imbalance of power to genders was something that I never, as a theoretical thinker, really got into in some depth, to try to understand what it was all about. So I've been doing a lot of homework in the last ten years, fifteen years. Which I hope I've still got enough energy and coherence left to express in the next ten years, of what I've been working on, in that sort of respect.

Can I ask you the sort of things that you have been working on in the last ten years or so?

Well, the main thing I've been working on in the last two or three years, specifically, and what I hope to come out with, some contribution to the discussion that is on sexuality. Which is something I've never addressed directly in sort of books like Sanity Madness and the Family, etc, etc. It doesn't explicitly pick up on the distribution of power between men and women. I wasn't denying that, as an issue, it's not addressed, it's not brought out into the book. Now that's the thing I want to point up..

That leads me quite nicely onto the next question I want to ask. You say that you've become increasingly interested in sexuality. I'd like to suggest that, in my view, Freud, along with Marx, Freud and Marx together, have made the

And, also, I'm living in London still. I've still got an active practice with patients and so forth. Really, to do justice to this, I've got to get out of London. I've got to get away from active practice. I've got to do nothing but immerse myself in the theory of this. I've got all the experience that I'm going to get. I've got to, to do justice to the magnitude and seriousness of the issue.

This is your plan? To take time off to do this?

Yeah. Yeah.

Can I ask you if you have seriously considered the work of Wilhelm Reich?

Oh, yes. Very much so.

Could you comment on his contribution?

Well, we'll leave out the last part of his life. What was most important was his emphasis on the literal physicality of depression and repression of physical energy and the repression and politicisation of genitality, you might say. Because he's in the '2os and '3os, in the middle of Europe, sort of looking at these millions of men who, like sheep..you know,' at this time of year in 1915,1916,etc, sort of millions of men of your age, and younger, in ditches that they've made for themselves, in fields, all over Europe, sort of living in mud, coated in mud. And when a whistle blows at 5 o' clock in the morning, they get up out of these ditches and walk, walk across fields with other men mowing them down, shelling them down, just sort of killing themselves at a rate of 100,000 a day. So Reich asked: How are these people brought up such that when they become 18, 19, 20, etc, they do that? The Mass Psychology of Fascism. About the only guy who really took that on. And there's no-one really.. Alice Miller, if you haven't come across..you should read Alice Miller. She's a Swiss lady in her 70s now, and she's written several books really getting into the early childhood of Hitler, for instance, and other people. What sorts of life did the nazis and fascists have, their training in their first years? She's got several books, one of the best of them is For Your Own Good, and her last one is Thou Shalt Not Be Aware, which really gets into it. She's made her mark in the German-speaking language. I can thoroughly recommend Alice Miller. I think this is her best one /fetches it from shelf/

Hidden Cruelty in Childhood Rearing, The Roots of Violence.

It sounds interesting. But does Alice Miller, like Reich, link the violence that goes on within families, for instance, specifically with the overall political-economic situation?

Yes. Not as specifically as Reich. But she digs into the... you see, political disinformation, lies, etc...within the power elite itself there's a tremendous explicitness about many of these things. For instance, Kissinger, before he became a politician, while he was still an academic, has got stuff written where he talks about, for instance, international negotiations, and arms deals and things like this, he says: It's totally impossible to put out in public what the deal actually is, as it goes on. That's obvious, anyway. But he considers whether, for instance, when the President, the top politicians, from,sort of, Russia and America, are negotiating, whether the politicians themselves, the top people who sign the agreement, ought to be told what the real agreement is.

So he's talking about the corruption that goes on behind the scenes? About the lies?

Well, he doesn't call it corruption, but he would say that perhaps it's better for the people who are for real about the negotiations not to tell the President or the Secretary of State what they've agreed about. So they can sign pieces of paper and believe it themselves, and go on television and talk about it. It's probably better that they themselves don't know what's happening. They're frontmen. You know - Reagan's just a Hollywood actor, that the guy's employ as a puppet.

Do you find that frightening?

I'm past finding it frightening. I think Reagan is not given nearly as much credit as he ought to be. If Henry Fonda had lived long enough he'd be sort of perfect President. John Wayne is a bit, you know, sort of..but I think Henry Fonda would have been, but unfortunately, just two years ago...

You might get the chance to vote for John Cleese, you know.

Well, I'm expecting the two presidents next, I would put my money on Jane Fonda as the first female president of the United States. Well, she's got a lot going for her.

Ha ha ha! Aerobics and whatnot.

Just imagine Jane Fonda in her late sixties, like Margaret Thatcher! She'd be unbeatable.

She would. Ooh, that doesn't bear thinking about, actually.

She's already the wife of..what's his name? The next move will be the Governess of California. That's the best step for Jane Fonda.

Yeah? I haven't been following her career, actually. So you think she's making a bid, do you?

Oh, yeah. She's coming along.

Well, we'll have to see about that. If we can just get back to psychiatry for a moment: very briefly, could you comment on Szasz? To Szasz, mental illness is always a social event, a moral and political event, whatever it may be as a cognitive event for the individual. For Szasz there is no such thing as mental illness, although there is certainly a suffering humanity. Do you agree with these statements?

I was at a conference last month, in Phoenix, Arizona, attended by over 7,000 people, mental health professionals from the United States of America, in which, among the presenters at this event was Thomas Szasz. I gave a speech, and he was discussant to the speech, and he got up and said that listening to R D Laing for an hour, trapped, as he was, on the stage, was the nearest he had ever got to involuntary incarceration! He can't stand my - I mean, you know, we're quite friendly - but he can't stand my mentality.

Can you stand his?

Oh, I can stand his. I very much like and admire his contribution to things, and his type of mentality. But he... well, the "but" is the sort of "but" that people put on me, you know: I've said all this and so on, but, what about all the macro-social, political, Marxist type of problematic that I haven't talked about? He does not address what is a decent human response to the type of misery that gets put the way of psychiatric nurses, social workers and psychiatrists. But his type of cutting through the cant, the hypocrisy, the deceit and the lies, and so forth that psychiatry and therapy and the world is all about, is absolutely exemplary. Also, one of the things about Szasz, he doesn't spend a great deal of time sort of blowing off himself. He quotes people all the time. All his books are full of references, of actual..saying:"This is - just read that again, what people have said". Every page he's bringing up what actual people, that he's attacking, are saying, themselves. And that's very fair.

To me, your work, and Szasz's work, perhaps to a greater extent, has made its greatest contribution by exposing psychiatry as ideology. I think Szasz makes that more explicit than you do. He has no truck with the mental illness concept at all..

Totally not.

Totally not. To him, psychiatry is pure ideology. Now, I get the feeling, particularly having read your latest book, Wisdom, Madness and Folly, that for you this is still a grey area. You seem to use notions of 'science', still, linked in with psychiatry. For you, psychiatry is still basically a scientific enterprise. Let me quote you! [reads] "Psychiatry tries to be as scientific, impersonal and objective as possible towards what is most personal and subjective".

"Psychiatry tries to be" and so on and so on.

Tries to be. But do you think fails to be? You see, for me, psychiatry...

Now, in Wisdom, Madness and Folly, you see, I can afford to adopt this sort of soft tone, in the book, because Szasz is in the world saying the sort of stuff that he is saying. I mean, if there wasn't Thomas Szasz in the world I would have to invent him! I'd have to be that myself. He does that!

So you're glad he's around!

Eh? Oh, very much so. It saves me having to write all that stuff he writes.

Do you agree, then, with my view, that there is such a thing as genuine science, that we can, as human beings, democratically seek the truth, for want of a better way of putting it, and that science, real genuine science, is concerned with the truth, but that has very little to do with Psychiatry?

Absolutely.

And that what Psychiatry does is masquerade as science, as truth, but is in fact pure ideology..

Yeah.

..and its main function is, as we said at the beginning, the policing of society?

Yes, it..

..and it can only get away with that by masquerading as science?

That's right. Completely.

..by convincing people that it is true..

Absolutely. Absolutely. I totally agree with you.

Right. So. I'd like to ask you, finally, how many compromises do you think you've had to make in your career? Perhaps I'd better explain that a little more carefully. You've taken a position distinctly in opposition to establishment Psychiatry, and I would imagine, from my own experience in psychiatry, that you have met a counter-reaction to you, to your views. I mean, I certainly have done, having taken your views on for myself, and I've been... I don't know what's the best word to use... perhaps 'persecuted' is a bit too strong, but I've lost my job, ultimately, and - I'm not blaming you for that! But I wonder how you've dealt with that? Whether it's been much of a problem to you, whether you feel that you have to compromise?

Well, since I'm still in the process, I'm not a dead man talking about myself in the past, I'm still very much embroiled with that. So, if I'm not going to lie in response to your question, I've got to exercise the greatest discretion in the way I respond to that. If I gave a completely candid and truthful, open, answer to that, I would be destroyed. I can't.

You can't answer it.

When I left the National Health Service at the point that, somewhere in the '60s, one of the remarks that one of the senior people in the medical profession made in comment, when I started Kingsley Hall, that - I can't say who this was - he said:"Laing has committed professional suicide". I didn't commit professional suicide, but as far as the psychiatric and medical profession is concerned, they have done their best over the last two decades to write me off, in other words, to assassinate and kill me. You will not find my name mentioned in many psychiatric textbooks. You can read all the psychiatric journals about what recent textbooks have been written on schizophrenia, etc, etc, that are purveyed to medical students, Laing or Szasz do not appear in the 20th century. You would think...so there's a concerted effort, not to kill me physically, but to erase..

..and discredit you..

And discredit. And that's still going on.

Oh, absolutely.

I've got to deal with that today. That's a serious impact, accusations and stuff. It goes on all the time. Now, I don't like that. I make no secret between ourselves that I've found that very difficult to survive it.

Nevertheless, my own experience is that when you take an opposite view to the established view, and also act upon that, that necessarily you will meet a reaction. And my way of dealing with that has been to work collectively, and to work in my position, with fellow-workers, in the union, in the Health Service unions. And I know the Health Service unions have to some extent a reputation for being in fact quite reactionary, and are so, on many issues. But, nevertheless, in my view, it's only through working with other workers, through unions, that you can hope to bring about democracy, hope to bring about change, and at the same time keep yourself sane. Because what management would like to do is to pick you off and isolate you, and ultimately drive you crazy!

You seem to me to be very much on your own. Very much an individualist. Now, to finish off the interview, I want to really ask you: Do you see yourself, having perhaps gone off and thought about things more, and written more, do you see yourself ever joining forces with, shall we say, mental health workers at a grassroots level, to bring about changes in psychiatry? Similarly, perhaps, to the way Basaglia worked? Do you see that as a possibility?

Oh, yeah.

I've stated it in rather a longwinded, roundabout way.

It hasn't been on the basis of any matter of principle that I've been not in that type of active network in this country. But I've found it necessary, just for my own survival, to get my own act together. And, sort of behind, sort of in the back of my mind, enormous confusion, I've been trying to clarify issues for a number of years. Which, I've been so preoccupied with that that I haven't regarded myself as readily available for more extravert, active engagement with such issues. I feel, in the last year, as I say, in particular, I've turned another corner and, as I was saying earlier, I've completed one phase, in more senses - literally and symbolically, my homework. And I'm on for anything, now.

Sorry?

Have you made a contact with David Hill?

Yes

Uh huh. I'm on for that sort of stuff.

You're interested in the British Network, the Campaign Against Psychiatric Oppression, that kind of thing?

Very much so.

I myself feel that those sorts of organisations are very interesting and encouraging, but I don't think they'll get anywhere - perhaps that's a bit of an overstatement - but I think they're going to have to link up with mental health workers, with psychiatric nurses, with people still working at grassroots level in the bins...

Absolutely. Yeah, the whole thing..

Otherwise they'll remain a fancy nice little alternative...

The whole thing will have to engage in a deeper sense of the issues of power in society at large.

Absolutely.

I mean, for instance, it's maladroit to develop a..a couple of guys have been making a film to be possibly shown on Channel 4, an outright sort of blast at drug companies, multinationals. It will be counterproductive. You've got to find another way of turning it around. I mean, I think it's a good thing to sort of put it out, absolutely straight, you know, just straight. But, but that in itself, if what is intended is to change things, that in itself will get a counter-reaction that. Like, those guys who made that film said it's very difficult because when they interview, if they try to interview, as they've done, the real senior, professional psychiatrists, they said: they're so plausible. That's why they're there. They're professional ideologists.

And they're very good at it. They're paid to be. So the reaction to the television film like that, which will come from the other side, they'll put their first team in, will be more convincing on the screen. You see, that won't be allowed to be repeated, and it will be, you know, there's a whole censorship board, and all sorts of committees, etc, that monitor what goes out on television.

So establishment reaction is going to get the last say?

Yes.

And they'll come across as more plausible.

Yes. So the point is one needs to have a permanent think-tank about strategy, and not just a sort of, you know, occassional...

Yeah. Permanent struggle.

Yeah, it's not just an occassional sort of peashooter sort of thing, it's got to be concerted and sustained, permanently, all the time. Because that's what these guys do.

That's right, that's their job.

Yeah. So got to get that act together *[sic]*.

And that's something that you see yourself as moving towards?

Oh, yeah. I would like to establish, somewhere in Europe, a quiet study centre, which would be a permanent think-meditation-strategic headquarters place, international, to get on thinking about this and taking, making moves here and there. Don't put that down because I don't want to announce it!

Ha ha ha!

No, you see, part of the thing is there's no need to put up a flag. Where you put up a flag it will be shot down. It tells people */*tape ends*]/*you are there and gives them the chance to set up a counter-reaction*]*.

..your own activity, you know, becomes a problem. You don't put your...you dig into the ground where you put your headquarters. The General High Command..of course, that's the wrong way to think about it..it's not a hierarchical structure, the stuff that's going on at grassroots; it's a completely different type of organisational network from the type of capitalist, hierarchical economic company system. And that has got to be thought out from the very nitty gritty. Because if groups like the Campaign Against Psychiatric Oppression organise themselves in the same sort of way as the capitalist business system, the structure of their thinking and activity will become similar to what they're attacking.

We don't want an elitist group.

No.

We don't want a vanguard party.

Yeah.

Thank you very much.

January 1986

Rick Hennelly

Improving the Quality of Mental Health Care - Now!

Mental health workers now operate from a whole variety of different settings - hospitals, hostels, health centres, area social service offices, day centres, community centres, etc. Each setting puts a different constraint on the individual worker. Those with the same status, eg. 'social worker', can have to carry out quite different activities: one-to-one psychotherapy can be quite different from liaising between groups and organisations.

Although the organisations we work for might dictate much of how we spend our time, we do still have some choice about what we do and how we do it. We can thus, and should, reshape our practice towards a community-oriented response, in order to try to avoid the widespread tendency to locate mental health problems "in" the person particularly afflicted.

Of course, individuals do report or manifest distress and we should do what we can to relieve it. It is also a fact that such people might usually perceive the cause of the distress as within themselves: "It's my nerves". And, responses focussing on the suffering individual do sometimes appear to be effective, at least temporarily.

However, there is now ample evidence suggesting that social, and in the broadest sense, political, and economic influences are the effective causes of most distress. Depression following bereavement is not such a strange response. Sexual abuse within the family might explain a young girl's self-destructive behaviour. Poor housing and poverty in the inner-city slum or high-rise could weel explain feelings of helplessness, anxiety or "low mood". A violent or oppressive husband could well precipitate a wife's feelings of incapacitating inadequacy or fear of social contact. Emotional conflict within the family might well trigger those extraordinary experiences that are now labelled "schizophrenic" - hallucinations of sight and hearing, manifests of real fears of persecution and deceit.

Evidence for the importance of such social and political forces has come both from sympathetic accounts and the accounts of the distressed themselves, and from large-scale statistical studies charting the relationships between deprivation and abuse and a range of undesireable feelings and behaviours.

Along with a growing awareness of the social causes of distress making emotional and intellectual and behavioural disorder, there is awareness that traditional, medically-oriented psychiatry is theoretically and practically quite bankrupt. There is not, and never has been, <u>any</u> evidence of a relation between mental disorder and physical lesion or chemical imbalance, with the physiological causing the intellectual and behavioural for any type of mental disorder other than those few cases of manifest genetic or brain-damaged disorder that we mark off, quite rightly, as <u>handicap</u>, not "illness".

Medically-oriented, "keep 'em quiet and get 'em back home" psychiatry refuses to recognise the sociological or historical viewpoint, and yet its own failings have been carefully documented. The history of failed treatments, from 19th century bleedings, vomittings, purges, duckings and spinnings to 20th century insulin coma therapy and the widely abused clumsy neurosurgical hacking bits off the brain, has exposed the insanity of the profession of psychiatry itself rather than of those the doctors ostensibly cure.

At the moment the profession is in a crisis of legitimacy. The role of psychiatrist has become almost untenable. The medical world holds psychiatry in low esteem, quite rightly, due to the charlatan, blundering nature of its empirical development and its lack of any well-argued medical 'armoury'.

Just now electroshock and the major tranquillisers are its most vaunted tools. There is considerable doubt about the real long-term effectiveness of ECT, and about the immediate hazards. In a few years ECT will probably be as discredited as any 19th century technique.

The major tranquillisers have said to have made possible an era of "community care", with which we are all blessed, since the 1950s. Clearly, they do effectively suppress unusual experiences or behaviours, in the short-term. But they are no cure for distress. With their introduction the 'open-door' policy of the hospitals proceeded apace, and the number of inmates declined rapidly. But the tranquilisers have recently come under stinging attack, as their long-term effects become clear. World-wide, millions have suffered what seems to be irreversible, manifest and crippling damage to the central nervous system. Hundreds of thousands in Europe alone - no-one knows how many - suffer from the drug-induced condition of 'tardive dyskinesia', which radically affects bodily coordination and posture. Nobody yet knows the full effects of long-term use of the major tranquillisers, but from the evidence so far accumulated, doctors should really be alarmed.

Recognising their lack of weight scientifically or medically, feeling like the Emperor With No Clothes, and responding to the shift towards community care, a few psychiatrists have responded by claiming an expertise in listening to the distressed, and in being able to identify the role of the social environment in the production of mental illness. However, their dilemma then becomes clear: they are exorbitantly paid medical practitioners trying to do what can be done as well, or better, by nurses, social workers, community-based psychologists, domicillary aides,etc.

I'm not here to rescue psychiatrists. But this tension is central to community-based mental health care. Psychiatrists have less of a role to play in such health care, and yet they have, by virtue of historical developments, been invested with a disproportionate amount of status and power over all mental health work.

This tension often reveals itself as a conflict between a 'medical model' of treatment, isolating the symptoms and the individual (as an ill patient), and the social/political model. This model views symptoms as such, not as being themselves the prime causes, and looks for the oppressive forces acting upon the one who is manifestly suffering, from within - as personal history - and from without - as his or her political circumstances - poverty, domination by parents, marital partner, etc.

It is essential to recognise the context I have outlined above. Without such an overview we cannot begin to consider possible strategies of intervention that will cope not only with the distress of the client but with the tensions and contradictions existing within the mental health services as they now stand. How can we explore and reshape our practices in this light?

There are a number of fronts, none especially spectacular, but which, cumulatively, could greatly improve our input to the mental health service. If we all made some conscious attitudinal and small organisational and practical shifts in our working routines, much could be achieved: mental well-being is precisely a matter of the mundane, the everyday, the 'invisible' routines of human rapport.

We can promote group activities which allow problems experienced by individuals to be explored and solutions suggested through voluntary participation in dialogue and negotiation. Dialogue is necessary for the person to speak out and find a sounding-board in order to isolate the causes of distress in his or her personal history and present circumstances. This may open up the possibilities of the person changing his or her life, by off-loading some of the weight of guilt, for example, onto the social environment.

Negotiation can take place between the individual and the immediate social network What is often negotiated is the removal of destructive behaviour, towards self or the group, in exchange for a more positive evaluation and better feelings by the immediate group. Such groups can develop an awareness that the person is, in a way, a sum of his or her relationships with others.

We can support the emergence of participation by users of mental health services and voluntary sector groups - MIND, National Schizophrenia Fellowship, etc - in the planning, organisation and delivery of services. A better service would build together, and share power. An emphasis could be made on the active participation of individuals in policy-making itself. Mutuality, cooperation should be emphasised. No-one has all the answers and everyone has problems of some kind. Control is an issue, and it should be avoided, since overcontrol taxes people's senses of confidence and purpose. Distinctions between roles should be minimised: doctor/patient, therapist/patient, professional/client.

We should refuse to collude in activites that exclude people who use services, and which serve to create classes within the services. This might mean thinking about the necessity for absolute confidentiality in all cases. It might mean questioning the ethics of discussing cases when the person concerned is absent. It might mean bringing those who use the mental health service into social events, conferences, meetings from which they have been traditionally excluded. We should recognise the strengths people can display even when they have certain disabling experiences. We should recognise their essential humanity. We should alter the balance of forces within the traditionally closed networks of professionals and require dialogue with, rather than about, individuals. The issue of confidentiality is important and involves certain contradictions: for instance, people have a right to privacy if they so wish, but the creation of supportive networks often requires the sharing of information about people.

We can build alliances with groups using the services. Such groups often come together when people want to rid themselves of isolation, and explore their problems together. We should encourage such groups to form and interlink, and help them to a voice by supporting their access to facilities aiding their development as a group: eg, let them use our rooms, phones, typewriters, meeting rooms, photocopiers. Better, help them get their own.

Join a network of individuals which shares common aims and problems in the delivery of community mental health. We need such networks for our own support, since those pressing for changes often come under attack from those pulling the system back. We can support others through such networks, those who might have more difficulties than we do.

We should try to spread information about good practices in mental health. We can try to establish wider discussion groups by encouraging concerned groups to get together on occassions, eg relatives' groups and church groups.

We should use a language purged of discriminatory attitudes. We should try to describe experiences and people without resorting to easy medical labels. Terms like "schizophrenia" or "personality disorder" don't necessarily mean much in terms of anyone's "essence". Rather they obscure real human needs by consigning people to the category of Can't Be Helped. Much of the vocabulary of psychiatry is as offensive as sexist and racist language: it denies the real value of the person so labelled. And there is no need for it. We can easily refer to the descriptions of experiences and feelings which the clients themselves offer. We should pay attention to their wishes and aspirations.

We should respond to the social, economic and political problems that lie behind medical "explanations" and the use of drugs. We should respond to these problems by urging the support required to be provided in locations chosen by those concerned, at the level they request. "Medical judgements" are often hasty and shallow. Behind them are entrenched problems of living that we really should encounter. When medical judgements are made and enforced we should persist in asking why and how they were made, whether information about the effects of such judgements is properly shared - eg the "side effects" of major tranquilisers or the short-term effects of minor tranquilisers. In more extreme circumstances, the proposed use of ECT, should always be challenged. ECT is not just a matter of debate. Scientifically unfounded and of very dubious origin and moral legitimacy, it must be opposed.

We can bring issues before a trade union audience, eg, we should speak up for "conscience clauses" in contracts for nurses who are unhappy about being forced to participate in psychiatric procedures which

they know are harmful.

We should press for the extension of democratic control of planning procedures which have traditionally been the preserve of distant "professional planners". At the same time, we can seek links with sympathetic people on policy-making bodies who should be urged to take up the issues. In particular, elected councillors on Social Services and Health District committees should be sought out.

We can argue for our Department, employer, team, unit, to have a value base, or set of principles for the delivery of the service. We can then use such statements of principle to challenge and change undemocratic practices and attitudes or policies which take no account of those who will be most effected by implementation.

We can strive to effect change with, not to, those who use the mental health services. The struggle to transform the Social Services or Health Service is the same struggle as that to change the circumstances of those whose lives are affected by the operation of these institutions, and who may spend a great deal of contact with, and be profoundly affected by,contact with them. In order to give a sense of value to those deeply affected by disturbances of feeling, thought or behaviour, it is necessary to create a climate in which those employed in the service also feel valued. Those who operate the services and those who receive the services all need to be able to express themselves, and need to be involved in decision-making. Real change, rather than more of the same, requires participation.

NURSE? WHAT'S IN A NAME? by Keith Sutton

Nursing has undergone radical changes during the last thirty years. Most of them for the better, we believe. But do some groups of nurses need to persist with the label of "nurse"?

Particularly those practising in the fields of psychiatry and mental handicap. The grassroots workers in those fields were absorbed into nursing because of various factors, and have established themselves as somewhat specialised within the wider career of "nursing". Virginia Henderson's definition of the "unique function of the nurse" does encompass those two fields of caring, but are the constraints of being junior partners in the profession actually detrimental to the effectiveness of nurses in psychiatry and mentall handicap? Does it at all effect the way care is given to the client population?

Simply because we are called "nurses" we unconsciously submerge ourselves in the medical model, and so limit our role and potential. Surely we should facilitate the emergence of potential, and it bemuses me as to how this role can be incorporated into the medical model of care.

Looking further, the people we care for need a consistent approach, not only in manner but in the length of time spent in contact with key individuals and support teams. Under the present system this seems to be unheard of. The approach seems to be one of perpetual referral between the various disciplines, so that, while we quietly slip out of a person's life, they are left to face an unfamiliar person, and develop from anew a trusting relationship. Where is the opportunity for healthy and honest relationships, in which individuals might sense they are equal partners, in the present regime?

There is a need for a reappraisal of the kind of support required by people who touch the psychiatric circus, and how the so-called professionals can adapt, bend, mould, or simply change their present roles to suit the reappraised needs.

The kind of demarcation that exists between the various disciplines in the mental health system, plus the overlapping of their roles, surely constitutes a very costly and ineffective service. Maybe the answer lies with specific agencies with individual areas of concern and responsibility, that is, for example, a statutory duty towards the mentally ill being invested in a single agency.

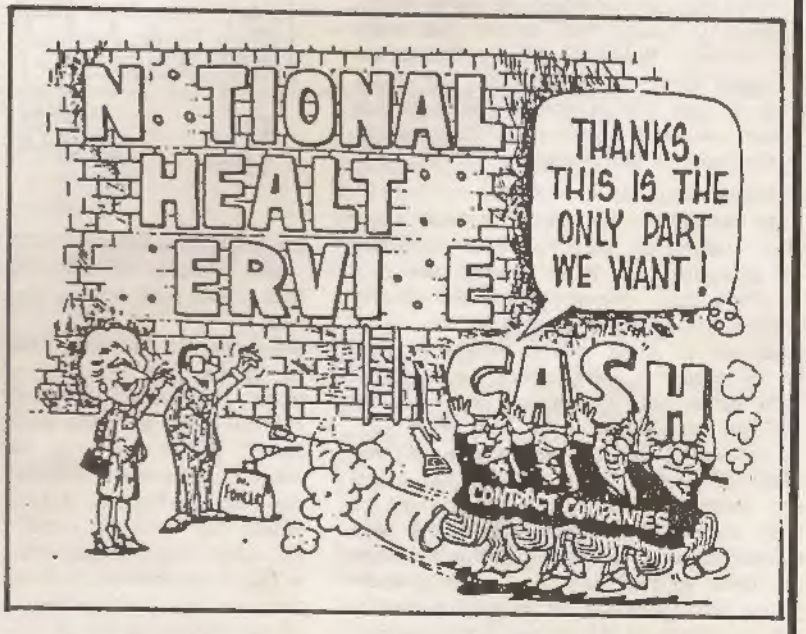
Whatever the answer, isn't this time of transition from a centralised institutional strategy of care to one based in the community also an opportunity to develop services to suit local needs, including the role of the professional workers?

PRIVATISATION

Few workers in the NHS won't realise the effects of privatisation on both patients and staff. But how many are aware of the full implications of the policy, which is to completely erode the state-funded service? Beginning with the ancillary services , it is only a matter of time before the whole organisation is given over to private enterprise. Health care will then no longer become an automatic right of the individual, but provision will accord with what the individual can afford; conditions within hospitals will no longer have to conform to high standards; workers will be at the mercy of private firms, probably staffed by non-unionised labour, paying less wages and offering much worse conditions of service. An exploited and unhappy workforce will not make for better health care.

The Tory view, ofcourse, is that privatisation is tremendously cost-effective and saves the country money. But just how cuts are to be implemented without a loss of service is glossed over. Those of us already working in the NHS know that the only significant way to reduce the costs of health care already running on the barest minimum staffing levels is to cut staff costs even further. This is not necessarily good, but actually false economy: due to low staffing levels at the moment, for example, almost one in three nurses suffers from back injury, are not therefore operating at full capac-

YOU HAVE A RIGHT TO KNOW WHATS HAPPENING IN YOUR HOSPITALS



OR DO YOU !!

ity, and have to take time off sick.

The Tories want us to believe that private companies are more cost-effective, but any fool can save money by worsening the service. Domestic cleaning hours are being cut by up to 40% in many plans. Whilst some irresponsible manager sits in his office making sweeping cuts on the 'in-house' tender, or some capitalist with no experience of health care cleaning decides he could make an easy profit, those out on the wards suffer.

Even when the contract remains 'in-house',domestic staff face the choice of taking redundancy or taking drastic cuts in hours, drastic cuts in pay and arbitrary changes in shift patterns . If the contract goes to a private company then no jobs are guaranteed and pay and conditions find a great reduction. Many domestic staff are already receiving no redundancy pay after years of service because management claims they are being offered reasonable alternatives - pay cuts of up to 60% due to the massive cuts in hours, and shift changes quite inappropriate to their domestic arrangements. For nursing staff, often already suffering from manifest staff shortages, privatisation means much more work, especially as the reorganisation, involving the employment of unskilled, untrained and unmotivated new domestic staff takes its time to 'settle in'. For the patients the consequences are obvious: dirty wards, reduced nursing care and the risk of infection.

So the Tory notion of cost-cutting is not necessarily good economics: workers join the dole queue, nursing staff go sick due to overwork, patients get worse and risk infection, thus necessitating longer stays in hospital. It isn't good economics, but it's good profits.

Atleast 25 Tory MPs are either major shareholders or directors of the private companies soliciting for private contracts. One such individual is Marcus Fox, Tory MP for Shipley and Director of Hospital Hygiene Services, which holds the domestic services contract at Highroyds Psychiatric Hospital in Leeds. That company took over the contract from Home County Cleaners. It busses women in from Bradford. The strong lobby of Tory MPs is concerned with cutting labour costs and maximising profits. Health is the least of their concerns.

GOVERNMENT CIRCULAR

The Government has decided to make specific changes to their previous circulars on privatisation. These changes are only in draft form. However, they have clearly decided to ensure NHS services are to be organised in a way that is more favourable to the commercial contractors. Up to August 1985 commercial contractors had obtained 116 out of 214 cleaning contracts(54%); 18 out of 59 laundry contracts(30.5%) and 4 out of 60 catering contracts(6.6%). Private contractors have been whining to the DHSS that the tendering conditions were not sufficiently favourable to them. Utilising their gang of Tory MPs to put pressure on the DHSS they have successfullt persauded the Government to change the ground rules.

The draft circular contains guidance "which all Health Authorities must follow". These guidelines include:

- a substantial monitoring role for RHAs with powers to intervene in DHA decisions and procedures and to deal with complaints against contractors.
- DHA must seek RHA approval for any alterations to the DHSS specimen tender documents and to draw tenderers' attention to such changes.
- DHAs must NOT specify terms and conditions of service.
- DHAs should only require performance bonds from contractors in exceptional circumstances and after consultation with the RHA
- DHAs should NOT ask contractors for details of union recognition, grievance procedures, performance rates of employees or estimated profits.
- contractors should NOT be charged for staff medicals or induction courses if required by the DHA.

'in-house' contracts to be monitored monthly and if costs cannot be contained within the set budget then the service should go out to tender again.

- Catering:
- catering services should be organised so as to create a genuine business opportunity to private contractors.
- catering contracts should be for the total district catering services so as to be more commercially attractive.
- Laundry:
- contractors should be offered the opportunity to tender for the provision of service in NHS laundries as well as their own premises.
- flexibility should be allowed in delivery schedules.

THE STRUGGLE AGAINST PRIVATISATION

Some examples of industrial action taken both inside and outside the Yorkshire region:

Newcastle: The 'in-house' tender was accepted by the DHA in early summer '85. The Union leadership saw this as a victory but the rank and file disagreed. The 'in-house' tender had only been accepted at the cost of massive cutbacks, reduced hours pay and conditions. Action was organised mainly by domestic staff but supported by other hospital workers. In August '85 a big demonstration took place in Newcastle town centre, supported by workers elsewhere in the region and beyond.

Sunderland: A decision by the DHA to award the domestic contract 'in-house' was defeated by the casting vote of the RHA Chairman. The contract went to ICC Cleaning Services. Industrial action followed.

York: In 2 out of the 3 psychiatric hospitals in the district the domestic contract was awarded 'in-house' at a cost of 30-40% reduction in cleaning hours. Industtial action failed to improve upon this. Action was successful, however, in keeping the domestic contract at York District Hospital 'in-house', even though the Health Authority had been keen to award it to ICC. The domestic contract of the 3rd psychiatric hospital in York, Naburn, goes out to tender on April 1st. As the hospital is already scheduled for closure within the next couple of years, many workers there feel despondent about their future.

Scalebor Park Hospital, Airedale: workers stopped work and put up a picket when ICC Cleaning Services came to look around.

Chapel Allerton Hospital, Leeds: private companies withdrew from the business of competitive tendering when workers refused to accept cutbacks and took industrial action.

Barking Hospital, near London: industrial action has been going on there for well over 18 months against the privatisation of domestic services. Further cutbacks were introduced there even after privatisation by the firm of Crothall and Co. In spite of this, Redbridge DHA voted to renew the contract.

Addenbrookes Hospital, Cambridge: industrial action had been going on there for well over a year against the privatisation of domestic services, after Cambridge DHA renewed their contract with OCS Hospital Services. At it's February meeting the COHSE National Executive Commitee voted 14 votes to 11 to withdraw official support from the struggle. NUPE has taken a similar decision. Shame on them!

Through their industrial action Sunderland ancillary staff forced the DHA to abandon it's programme of tendering.

Elsewhere the picture is more gloomy. In Yorkshire, for example, there has been the privatisation of the laundry sevices and the boilerhouse at Wakefield; domestic services at a cost of 312 jobs at Pontefract; and at Halifax, although the 'in-house' tender was superior by £100,000, the Government ordered the DHA to go private.

THE NEED FOR A NATIONAL CAMPAIGN

The TUC has made noises, but its leadership has not instigated a concerted campaign against the Tory rundown of the proudest victory of the British working class, the National Health Service. The Health Service Unions have no national campaigns or strategy. There have been isolated struggles, but nothing concerted through the union apparatus. Members of COHSE and NUPE should get along to their branch meetings and demand that their unions, at the national level, present positive programmes and fully support all their local memberships resisting the rundown of health care and the loss of jobs.

Why could not COHSE and NUPE, preferably together, hold a National Conference on privatisation? Such a conference could discuss tactics and strategy for resistance to the Tory profiteers. It must also try to achieve some positive ideas about possible modes of increasing the efficiency of the organisation and efficiency of

the NHS - but ideas that do not involve the false economies of increased exploitation and worse services in a race for profits, but rather provide better services involving the experienced staff already employed. Privatisation has begun - but unless we do something it has far from run its course.

Lyn Bigwood

ed the concept of therapeutic communities in psychiatric health care and set up a unique service at the Connelly in Birmingham where the day centre aimed at providing a better psychiatric service for the Asian and Afro-Caribean community; she has campaigned against the abuse of psychiatry in prisons and the widespread drugging of prisoners and has done a lot of work representing prisoners and patients on Mental Health Tribunals.

'When I went to Birmingham I found myself faced with having to provide a psychiatric service for a large Asian population and many of the women did not speak English well enough to discuss their psychiatric problems...I found they were getting a very inadequate service and thought: this will not do, I have to do something...I managed to get a special service started up (aided by Asian nurses) ..A lot of the women were getting depressed because they were isolated at home during the day..A therapy group was developed and I had a special clinic every week..we used to get a lot of referrals from local maternity hospitals. Asian women having babies felt alienated and didn't know what was going on if they didn't speak English. Say the baby was put in intensive care and it wasn't explained to them why, they would think it had been taken away.. They would react with what looked like a psychosis.. but very often it stopped when things were explained to them and they were reassured.'

This service, the first of its kind, proved so popular that it attracted people from all over the country. Despite this popularity the service was run on a shoestring by the Health Authority, who made it clear that they attached little importance to it. Dr O'Shea's fight on this and other issues did not endear her to the Health Authorities.

Dr Maire O'Shea, 'Conspiracy' & the PTA

After 18 days in Court, Dr O'Shea was acquitted and awarded £40,000 costs (having been refused legal aid). Since the other three defendants had pleaded guilty, the £1 million trial really focussed on Dr O'Shea. She attributes her success to her determined resistance to a Special Branch frame-up, to her able defence, and to the fact that she had spent the year before campaigning publicly against her arraignment. On the evidence, the judge directed the jury to find her not guilty, despite determined efforts to get her found guilty by political association.

Organised public campaigning succeeded against anti-Irish racism and the secrecy and intimidation of the PTA and conspiracy laws.

WHO IS DR MAIRE O'SHEA?

"As well as campaigning on the Irish question, Dr O'Shea has spent thirty years in England working in the NHS, in which time she has fought many battles: she has opposed hospital closures; she pioneer-

'...people have said that some of my medical political activities must have something to do with me being charged, because there were a number of people who would have liked to be rid of me...' "
Fight Racism! Fight Imperialism! March 1986

Dr Maire O'Shea officially retired in November 1984, but continued to work part-time at the day centre.

On New Year's Eve, 15 months ago, she heard, whilst visiting Ireland, that the Special Branch had searched her English home, under the Prevention of Terrorism Act. Immediately she informed the media - publicity has been a hallmark of her fightback. When she got back home she found that files and confidential papers relating to private matters and to patients and to her work on the Mental Health Tribunal had been broken into and some taken away.

Six Special Branch and police then arrived and took her immediately into custody, and then onto the Bridewell, Liverpool. She was held in solitary confinement and

Conspiracy trial held in camera

The trial of the five people arrested under the PTA December 1984 opened in Manchester on 14 January amidst intimidation and secrecy virtually amounting to 'in camera' proceedings. The major charge is that the defendants conspired together with others to cause an explosion in the United Kingdom, of a nature likely to endanger life or cause serious injury to property. Peter Jordan has pleaded guilty. Peter Lynch pleaded not guilty to the conspiracy charge and this was accepted by the prosecution. On the eighth day of the trial William Grimes also pleaded guilty to conspiracy. The remaining two are Maire O'Shea (66) and Patrick Brazil who are pleading not guilty.

On the first day of the trial, three of the men were brought to the court from Risley in a convoy of twelve police cars leading three vans, one defendant in each, with twelve more cars bringing up the rear. A helicopter accompanied this speeding entourage to the court and will have had a good view of the convoy smashing off a bumper from a private car in the car park. Literally hundreds of armed police had sealed off a large area of Manchester city centre and anyone attending the court was confronted by rooftop snipers, men in army drill with rolled up balaclavas, alsatians, security cameras, a metal detector gangway and repeated close body searches. All this to ensure that the jury, the press and the British public all got the desired impression that the remaining defendants, all Irish, were guilty even before a word was uttered in the courtroom. The advice of Justice Mann to the jurors not to draw any inference from the high level of security about the guilt of the defendants had a cynical ring to it.

Mann's intentions in this the latest Irish show trial were made clear on day one when he endorsed the exclusion of the public from the 'public' gallery. Out of 36 seats only one place was allocated to relatives and friends of the five. This one seat was only granted after strong protest. The representative of Patrick Brazil's family was denied entry. So too the official observer from Maire's trade union ASTMS, representatives of the ISM including myself and journalists from *The Observer*, *Irish Post*, *Morning Star* and RTE (Irish TV and radio). As the Manchester Maire O'Shea Support Committee press statement said, 'In effect it is the Police Special Branch who are not only providing the prosecution evidence but also preventing defence observers from entering the court.' Mann justified this exclusion of the public by saying that the press were the guardians of our liberties! The assembled hacks promptly disproved him by failing to report the restriction of the public gallery. Only the *Irish Times* mentioned it. For the rest of the trial, Mann has 'conceded' that any press seats still vacant at the day's outset can be used by the public – never more than four people got in the rest of the first week. Mann has thus stage-managed the trial so that the prosecution case is fed to the press vultures (aided by photocopied evidence distributed by the police in the court) with the public excluded.

From the outset the political nature of the trial has been undisguised. The prosecution has openly tried to influence the jury by going into the political affiliations of Maire O'Shea, Peter Jordan and another man named in the conspiracy, Daniel Ryan; that they were all past members of the Communist Party; that Ryan had been a member of Official Sinn Fein (now the reactionary Workers Party) and left it; that Maire and Jordan were involved in the Irish in Britain Representation Group and the Troops Out Movement; and that Maire wanted a united Ireland and regarded Irish people in prison in England for 'terrorist' offences as victims of the British occupation of the North of Ireland. Having implied guilt by association with political views and membership of legal political organisations, the prosecution had the affrontery to add 'This is not a political trial'.

Considerable pressure prior to the trial forced the Irish Embassy to send an observer to the first day of the trial. She refused every request for help on the day and has not been seen since.

FRFI and ISM comrades attended the Manchester Support Committee's sixty strong public meeting on the evening before the trial, where speakers included Dave Douglass, from Doncaster NUM and the Yorkshire Executive, and Pauline Sellars for FRFI. We helped respond to the situation on day one of the trial. The O'Shea Support Committee had some success with Manchester Piccadilly Radio interviewing the excluded ASTMS observer and the *Irish Times* quoting the press statement at length.

Tony Sherida

From:
Fight Racism! Fight Imperialism! February 1986

refused access to a solicitor for five days, meanwhile being interrogated twice a day. The police surgeon was insulting and aggressive and wanted to interfere with the dressing on her bad leg. She feels she became otherwise well fed and cared for because she had alerted the media and they were taking an interest in her case

She was finally charged with "conspiracy to cause an explosion in the UK". She was supposed to be a go-between for Sinn Fein. True, she was acquainted with one other charged. But the politically active Irish in England are few and far between. Later, just before the trial, she was charged also with "witholding information".

Having been charged she was remanded without bail. With a minimum ten year's imprisonment hanging over her head, the police felt she might skip bail or obstruct their investigations. They also said they were concerned for her welfare: her neighbours might harrass her. That is not so far-fetched. Many Irish suffer from harrassment for the crime of being picked up under the PTA. But Dr O'Shea is a very popular member of her community, and when she got out she found great sympathy for her from her ethnic minority friends, especially.

But, meanwhile, she was held in solitary confinement at Risley prison, with very little exercise, and able only to see her closest relative. Other relatives and friends were invited to apply for permission to see her, and they dutifully filled in forms and supplied photos of themselves: the Special Branch "fact-gathering" on the cheap. Her daughter lost her job in order to visit her. Visits were brief and taperecorded. She was told she could not see a solicitor because the police were (in 1985) "implementing the 1986 Police Act".

After four weeks of solitary at Risley, and after
and after something of a campaign of letters from prominent politicians and professionals to the Home Office, and when it had become clear that there was no real evidence against her, a magistrate reluctantly freed her "due to pressure from above" and "on humanitarian grounds". The day before she was released she was mysteriously taken off of Category A status (dangerous). No conditions of bail were imposed. So did the State now consider her harmless? If so, why did they not drop the whole thing?

Her home was invaded, property damaged and taken, she has been strip-searched, moved secretly from prison to prison, held in solitary confinement. While on beil she was again harrassed by Special Branch, and so has her family since she was first held. The Birmingham Health Authority took the opportunity to deprive her of her job. The police did not return the property, nor pay for the damage they caused. It took four months for her defence to get the prosecution papers, and apparently they then turned out to contain no admissable evidence against her. Finally, a hospital offered her a bed for a hip-replacement operation for a date just after the trial was to begin. The judge refused to delay the trial. Now she is back on the waiting list.

WHAT IS THE PTA AND CONSPIRACY LAW?

The Prevention of Terrorism Act, already prepared, was introduced and rushed through Parliament in the wake of the Birmingham pub bombings of 1974. Under the Act there have been 6,200 arrests. But only something over 100 people have been charged with anything. A strange ratio. Further, most of those were charged with trivial offences such as drunk and disorderly. But detentions under the PTA, holding Irish people for less than 12 hours now run at about 44,000 a year. Is the Act being used to inconvenience and intimidate the Irish in England? To put fear into those who might organise to protest the British presence in Northern Ireland? Dr O'Shea says there has been a dramatic decrease in Irish political activity in England since the introduction of the PTA.

Dr O'Shea was an executive member of the Socialist Medical Association until it refused to condemn doctors certifying detainees fit for torture in Northern Ireland. She was a constant thorn inthe side of her health Authority. At the time of her arrest she was resisting their attempts to victimise a nurse. She was a member of the Labour Party and ASTMS. But worse, as it were, she has been a member of the Irish in Britain Representation Group, opposed to the PTA itself, for the last four years. Moreover, in the light of new evidence about the Birmingham pub bombings, suggesting that the convicted were not guilty, she had just started to work on a defence of the six men before her arrest.

In her opinion, the PTA is used to silence Irish dissent in England. But in order to appear legitimate, the PTA needs to find plausible suspects and make prosecutions, in order to justify the Act being on the books.

The PTA was introduced by the then Labour Home Secretary, Roy Jenkins, as a temporary extension of the old Emergency Powers Acts. It was expressly aimed at the IRA. On suspicion of terrorism one can be held in secret for 48 hours. Then a magistrate can decide, in secret, to extend that time. The Home Secretary is empowered to waive Habeus Corpus, without there being any charge, and without giving any reasons for his decision. He can likewise ban anyone from the UK, or any part of it, or restrict a person's movements. This has happened to a lot of Irish-born and their English-born children. They have been "sent back" to Ireland. The PTA is used for "fishing": "suspicion" lets the Special Branch turn-over a home in a random search for information.

After the PTA was introduced the Special Branch's allocations in the yearly police budgets noticeably increased. Now the figures are not routinely published. Only recently has there been any sort of lobby of MPS against the Act's being yearly renewed "on the nod". 109 MPs have just voted against it, but it was easily renewed It is official Labour Party policy to scrap it.

Conspiracy has a venerable history. It was used against the Tolpuddle Martyrs, against the Chartists, against Fenians, against trade unionists in recent times. Possession of literature seems to be sufficient evidence. In Dr O'Shea's case the use of the PTA and of the charge of conspiracy seems dependent on the immediate political climate: her involvement with those convicted of the pub bombings and the Government's need for an escalation of PTA arrests and charges since the electoral successes of Sinn Fein in Northern Ireland."Catching" terrorists will "prove" the danger of Sinn Fein.

Dr O'Shea's might be one of the last cases under the PTA. Now the Chief Constables' recommendations have been embodied in the 1986 Police Act, which incorporates, on a permanent basis, the PTA and the "Suss" laws. You are no longer presumed innocent: you can be charged with withholding information. You can be arrested on suspicion, you have no right to remain silent, and there will be no right of Habeus Corpus.

For further information contact: Dr Maire O'Shea Support Committee, c/o 448 Stratford Road, Birmingham, B11 4AE

Boycott South Africa!

*Britain is the third largest source of imports and the third largest market for South African products.

*UK owned companies employ 7% of the total South African workforce.

Investment in South Africa is profitable because the black workforce is exploited. Wages are chronically low, health and safety provisions almost non existent and trade union rights only just becoming established.

Deepening crisis

The crisis in South Africa is deepening as the repressive and brutal regime struggles to cope with the escalating resistance and rebellion of the majority black population.

The Apartheid regime has meant that the white population, comprising 15% of the whole, has exploited and terrorised the African population who comprise 75% of the whole. They have been excluded from any real participation in society, denied the chance of a normal life, and subjected to many repressive and inhumane practices ranging from the iniquitous pass laws to arbitrary arrest, imprisonment and torture by the white security forces.

There are two health services in South Africa, a good one for whites and an inadequate one for blacks. Black nurses are paid much less than white nurses and patients cannot be treated by people of a different race.

Britain a major sanctions-buster

The Apartheid regime has been condemned and isolated from the community of nations. However, economic and social sanctions imposed by the United Nations have not been effective because they have been largely ignored.

One of the major sanction busters has been Britain. Because of our colonial history Britain's links with South Africa are the most important of its links to the outside world. The Apartheid regime's dependence on Britain is surprisingly large.

*between 40 and 45% of all foreign investment in South Africa is British.

If the British Government won't enforce its own embargo, British trade unionists can. The TUC is urging member unions to develop ways of extending the boycott.

Pressure on Health Authorities

COHSE's NEC recently carried a motion urging the boycott to be extended to health authorities whose support of the Apartheid regime ranges from investments in companies with interests in South Africa, to buying goods produced in South Africa.

It is important that maximum pressure be mounted on all health authorities to extend the boycott. The following action is therefore suggested by branches:

*Write a letter to your health authority to clarify its position on investment in South Africa and purchase of South African goods. Does it invest in South Africa directly or indirectly? A model letter is set out below.

*Contact Head Office or the Anti-Apartheid Movement, 13 Mandela Street, London NW1 0DW, telephone 01 387 7966 if you require detailed lists of companies with South African involvement or lists of South African brand names.

from: COHSE Gen Sec's News.

"Sanctions are vital. Some people say they hurt the blacks. But don't worry about us. We've been suffering since the first white colonialists set foot in our country, in the 17th century. Sanctions are the only way to stop the bloodshed." ANC TU representative, Anti-Apartheid TU Conference, London, March 1986.

WORKERS with Portsmouth District Health Authority, are taking determined action in support of black workers in South Africa.

NUPE members in the Stores are refusing to handle South African goods after the health authority refused to seek alternative supplies. Management have hit back by cutting their pay and sending them home early: their take-home pay has now dropped to just £55.50 per week.

The boycott action has been backed by TGWU and NUPE drivers who are refusing to transport the goods. The *Morning Star* reports that:

"The refusal of one driver to move three tins of pears yesterday led to the health authority management withdrawing the bonus of all 17 drivers and sending them home early."

The action has been effective in preventing the removal of any South African goods from the stores. And kitchen staff have agreed not to handle the food if management do succeed in moving it.

Following the recent massive strike by black hospital workers in Soweto, South Africa, the Portsmouth fight raises the whole question of solidarity action against apartheid among hospital unions.

COHSE's Region 6 which includes North West London has a consistent policy of opposing apartheid and carrying out a publicity campaign in its branches.

Last year's COHSE Conference heard from a South African speaker that apartheid laws mean white staff caring only for white patients, and people dying if a "whites only" ambulance turns up at an accident involving black people.

NON-STOP OUTSIDE SOUTH AFRICA HOUSE TRAFALGAR SQUARE

PICKET

■ RELEASE NELSON MANDELA
■ RELEASE ALL SOUTH AFRICAN POLITICAL PRISONERS
■ CLOSE DOWN THE RACIST SOUTH AFRICAN EMBASSY

19 APRIL **DEMONSTRATE**
Assemble 2 pm
Bidborough St, Nearest tube Kings Cross.

MARCH TO TRAFALGAR SQUARE TO START THE NON-STOP PICKET AT 4PM

CITY OF LONDON ANTI-APARTHEID GROUP Tel 837-6050 FOR DETAILS
FUNDED BY THE GLC

The Stanley Royd Poisonings

At going to press we have yet to actually see the Government Enquiry Report into the outbreak of Salmonella poisoning at Stanley Royd Hospital last year. Many patients and staff suffered from the epidemic, and it is now reckoned that 19 patients died as a direct result.

According to the COHSE newspaper, however, the major blame was "human error" and bad management.

The remit of the enquiry team was just to cover the cause of the outbreak and not to investigate the NHS cuts and closures at Wakefield, or the low-staffing levels. Consequently, and simplistically, the cause is located in the kitchens. New staff now run the kitchens, and control has been tightened up there. The report recommends more qualified staff on the wards and adequate linen and clothing on the wards. All of which might be positive measures. But really, there is more to the story than that.

And that is no doubt why District General Manager Brian Birchall has issued a directive that:"No member of staff should volunteer or otherwise provide information on this subject to anyone outside the Wakefield Health Authority."

Now why should that be? What has that got to do with improving conditions? Staff at Stanley Royd fear that management will now be looking for scapegoats, threatened as they are with disciplinary action for breaching confidentiality. Since when has hospital management come under the Official Secrets Act?

It is true, as the report says, that the kitchens were the source of the outbreak, no doubt. But why did the report "..find it impossible to recommend any change in the law on the vexed question of Crown Immunity"? In 1978 those kitchens had been reported as a "culinary disaster area", and nothing changed in the meantime. Why was management not responsible for putting the kitchens in order?

The report does condemn the managers who chose to attend meetings about the outbreak rather than get onto the wards to attend to the tragedy. Here we get closer to the deeper, underlying causes of the spread of the outbreak: bad management and low staffing levels due to the cuts.

At the time of the outbreak a nurse at Stanley Royd wrote anonymously to the Observer. She pointed out that almost half the patients, and an unspecified, but large number of nurses had been infected. Management were lucky to contain the spread, given their delayed and inadequate response, and the dreadful conditions of work that are normal within the hospital.

Management positively refused outside help at the time of the crisis, being unwilling to admit they could not cope. And yet, of course, the hospital runs on a bare minimum of staff, normally, and management only drafted in staff from other areas within the hospital. Nurses who had to go sick during the epidemic were brought back onto duty when "symptom free". Normally, in other authorities, three negative specimens should be obtained before the nurse can go back to work. This might take months. But if not, such nurses might still well be carriers, reinfecting the hospital.

It is true that there was insufficient equipment - on one ward, during the epidemic, one thermometer served for 22 patients. Barrier nursing broke down. Normally, nurses are moved from ward to ward during a shift, in order to provide stand-in staff at meal times, during bed rounds, medicine rounds, etc. Some staff are expected to work on three wards in a shift. Without this unwritten agreement, the hospital would, normally, grind to a halt. Under the stress of the outbreak, when nursing staff were still rushing from ward to ward under the emergency conditions, it is easy to see why the infection spread so rapidly and thoroughly. Under normal conditions, every little crisis becomes, due to staff shortages, a possible major disaster.

Added to this, under the pressure of the threat of privatisation, and due to general economising, the ancillary services could not cope. The food had already deteriorated before the outbreak, due to the cuts. The Laundry couldn't cope during the crisis. Patients had to sleep on paper disposable sheets, and infected linen was piled up, inadequatley bagged, in corridors outside the wards. Patients and staff were continually exposed to the risks of further infection.

Management should shout about the cuts, not try to cover up the real reasons for the breakdown of a hospital suddenly faced with a bit more pressure. Salmonella is normally present in food, especially meats. It might start in the kitchens, but the spread of a runaway epidemic is due to lack of staff and the management cover up of that fact. A routine event became a major crisis, and 19 people died. Still, they were only mental patients, weren't they?

Nurse management and hospital administration try to keep the lid on the crisis in general. The Stanley Royd salmonella outbreak was only a particularly glaring example of the crisis. Nurses and other health workers are scared to speak out for fear of victimisation. Now, what are we doing tolerating public servants who act like petty dictators, whose failure in an emergency causes widespread distress amongst its staff and patients, and a number of unnecessary deaths, and then turns round and tells its workforce to shut up?

Under these circumstances it seems right and proper that workers at Stanley Royd, and indeed at any hospital where corners are dangerously cut, should be encouraged to speak out, anonymously, through their unions. Better still, shout out, to the press and to whoever will listen.

The MIND Conference 28-29 Nov. '85

Lyn Bigwood

At the end of November last year MIND held a two day conference: "From Patients To People". 750 people in Kensington Town Hall. And, as if to show our intentions, there are indeed many who look as if they have made the transition from people to patients and back again, with the scars to show for it. Sharing the platform with Lord Ennals is a woman who tells us her father committed incest with her when she was 11, a man talking about his problems with drink and drugs, another tells of Largactil experiences, another who was incarcerated for 20 years. An Indian woman talks of the plight of many immigrants and the severe stress caused by racism, as well as the sheer practical problems of language and cultural difficulties. Women from Bristol talk of the factors in women's lives that lead them to be diagnosed mentally ill twice as frequently as men - the socialisation into emotionality, the isolation and frustration of their lives, the behaviour considered mad merely because it is a woman acting it out.

Between each contribution one got the uncomfortable feeling that Lord Ennals was abusing his position as Chairman by patronising each speaker's piece, disguised as "encouragement". He reassures women that they needn't worry about the statistics on them in relation to mental health, they just reflect the fact that women live longer. Later he apologises about that "throw-away remark".

Lunchtime. Time to see the stalls in the foyer. MIND have a rather pathetic display of blown-up newspaper cuttings, containing the word "mad". "Images of Madness Portrayed in the Media". Is that really the extent of psychiatric oppression? The Campaign Against Psychiatric Oppression think not. They distribute copies of their manifesto, describing the function of psychiatry as an agent of control under capitalism, leaflets on the politics of madness, information on major tranquilisers, petitions on the abolition of shock treatment, poems written by former inmates. They share a stall with the British Network of Alternatives to Psychiatry. Many appear to belong to both groups.

Much of the time spent sitting on their stall is taken up listening to desperate people who come up and relate their personal horror stories that they have never been able to get anyone else to listen to. What begins as heavy, bizarre-sounding ravings gradually emerge as fairly coherent stories of consistent abuse from family, doctors, psychiatrists, bosses, and ends as an intelligent and sensitive woman apologising for going on and on and sounding so crazy, but you see it's been building up for years.

People are warmly invited to attend the meetings of the groups.

Other stalls sell various books and information about various country-wide community-based schemes of mental health support.

I spend the afternoon in CAPO's workshop: "Who Are the Real Consumers?" Eric, a survivor of many years in the bin, argues that the real consumers are not the patients, but those with vested interests in putting people away. He thinks the term "consumer" is ridiculous: "It's like calling a woodlouse a consumer of Rentakill".

Some of the professionals think this is going too far. "You're surely not suggesting that all of psychiatry is bad? I mean, we accept that bits are bad, but you go too far".

CAPO reply that psychiatry is never helpful, can't be, because its first and foremost function is social control. As for psychiatric treatments, they are barbaric and extremely dangerous. About 25 million are estimated to suffer from permanent brain damage due to taking major tranquilisers.

Here, again, the professionals intervene: "Where's your evidence? Lets's be scientific about this. You're getting too emotional". Yet those making most of the song and dance, most of the emotion, turn out not to have bothered to have read CAPO's manifesto, nor to be able to argue any real case back. Why did they come to the workshop? To defend their vested interest by merely pulling rank?

I suggested that CAPO forge links with sympathetic mental health workers through their union branches, as a means of achieving some sort of positive action. Unsurprisingly, considering their experience of mental health workers, CAPO representatives admit to a suspicion of working alongside mental health workers who have delivered them previously nothing but bad news.

The second day: I go to a workshop of the British Network of Alternatives to Psychiatry. A psychiatrist, Steve Ticktin, tells us the Network began as a branch of the International Network, itself formed in Brussels ten years ago. The discussion turns to community care and the Tory plans to do it on the cheap.

A couple of people then reported their positive help from Philadelphia Association houses, one in Canada, one in the UK. A similar house is being set up, Asclepion, a place where people can live in a supportive but non-authoritarian environment which allows one the freedom to move on at any time. What is needed, it is felt, is sympathetic ears and help when asked for, not a place where everything is done for the person with troubles.

Then someone says:"What about the elderly, those with senile dementia?" This meets a counter-accusation:"Don't write people off just because they are old and seem to have outlived their usefulness". But everyone seems reluctant to tackle this issue. Finally someone recalls a network of support for the elderly who live in the community, and the tension is relieved. Everyone breathes a sigh of relief.

In the afternoon I go to David Hill's session on "The Politics of Schizophrenia", this time as speaker, too. A member of CAPO, Mike Lawson, reads a poem. Then Hill talks about the unscientific nature of the concept of schizophrenia, and the damage done by applying the label to people. He gives us the horrifying facts and figures about psychiatry's "treatments". Minor tranquilisers are extremely addictive, and dished out to millions every year. Major tranquilisers, it is now well documented, cause major irreversible damage to the brain and central nervous system, and are nothing but poisons to shut people up. Shock treatment is nothing but a "pragmatic", quite unscientific, electrocution, and must be abolished. Psychosurgery, likewise, has no real scientific basis, but it can destroy functions and hence quieten people. There is now a particularly horrific "advance" - implants of radioactive material in the brain.

Another poem, by Peter Campbell, followed, and then it was my turn to talk. I suggested that effective rsponse to the system of psychiatry would only come about through collective work, mental health workers along with inmates and ex-inmates, through the unions and affiliated organisations such as CAPO. I offered some practical ideas: compile systematic dossiers of complaints to expose bad practices in the bins, get topics such as the politics of mental health on the agendas for union discussion, publish regular newsletters for workers and inmates to contribute to, campaign against management dictated privatisation and hospital closures, begin to think about hospital occupations unless proper community facilities are forthcoming, forge links with left groups who could support such campaigns, get the support of workers in other than health service unions - they have the power and they are the consumers of the Health Service.

A Vote on Psychiatric Treatment

Throughout the Conference CAPO and the British Network asked people to vote on four issues. Nearly half responded. At the plenary session David Hill read out the results:

Conference condemns any attempt to suppress expressions of emotional distress, and to dismiss such states as illness.
For: 269 against: 27

Conference demands that the long-standing proposals to close psychiatric hospitals be rapidly implemented; and that "community care" be transformed from a cosmetic, cost-cutting exercise into the meeting of common human needs for housing, income and love, as determined equally by users and providers.
For: 236 against: 31

Conference demands the abolition of "Electro-Convulsive-Therapy"
For: 221 against: 72

Conference believes that the abuse of power by the medical and mental health professionals - including the use of involuntary incarceration and the use of brain-damaging and addictive drugs - represents an unacceptable form of institutionalised violence.
For 244 against 54

From this you can see that something under half of those at the conference took a genuine interest in these issues, and in any democratic process. You might also say that over half, at this most "caring" event, couldn't give a damn about arguing a case or the process of democratically sounding opinion. That's the way it is: few of those supporting the status quo are willing to participate in any democracy of decisionmaking. All power to those who agreed with the proposals. It should also be remembered that small numbers of motivated and organised people can achieve quite a bit if they've a real mind to do so. The "left wing", or however you might conceive it, at the MIND conference, made up a substantial minority, on these counts.

The Conference wound up with a brief restatement of some of the views expressed on the first morning. There seemed to be general agreement that there should be more women and ethnic minority representation on the platform, and at the conference in general.

MIND's Director attempted a summing up, but nothing he said stuck in my memory. Perhaps he said little, perhaps I was suffering from overkill.

I suppose the conference was a success. Ideas were shared and contacts made.

But I can't help thinking that the emphasis on isolated examples of good practice, laudable as they may be, gives an unreal picture of the state of psychiatry today - barbaric, chaotic, and getting worse.

It was great to see so many ex-inmates getting up and telling their stories. But too many seemed to think that was enough: leave it to them to show us the way. Of course, we can learn. But it seems like a cop-out to expect them, with the lack of power that they have, to lead us who hold jobs in the service.

Finally, a word about language. I don't think that calling someone a "consumer" or "user" of a service, rather than a "patient", changes anything very much. I think "inmate" more adequately reflects the situation of nearly all those on the receiving end of psychiatry, whose institutions are more like prisons and concentration camps than hospitals. Similarly, I can't see the improvement in talking about "providers of services". There can only be one category of person employed in the psychiatric set-up, and that is: worker. Beware the "professional". He is just someone who turns the other way when it comes to cleaning up the shit.

As I was leaving the Town Hall a man approached me. He had quite unnerved me the day before, with what seemed to be a very menacing appearance. "listen", he said, "I like being called a nutter. What we need is more humour." He offered to do some cartoons for the magazine. I hope he does.

LONDON HEALTH EMERGENCY. MARCH '86

Occupational hazards

● The collapse of the staff occupation at Neasden Hospital in Brent has reopened the debate on the most effective tactics to resist health cuts.

The ill fated occupation was launched in mid-October with representatives of the 140 staff, supporters and unions forming an occupation committee.

'At first it was exhilarating to feel we were exercising some control over our health service,' says one of the campaigners Len Bateman. 'But then it went a bit funny and by the end people were disillusioned. We felt angry that the unions decided to back down.'

Peter Marshall, COHSE regional officer says of the pickets, 'having spent hours and hours of their time their anger is justified'.

But when the bailiffs finally came, accompanied by about 20 police in a pre-dawn swoop, they found only Len Bateman and Maggie Smith at the gate. The two left quietly.

Outside the hospital support had been patchy. Some pensioners and women's groups and Labour activists participated, but the wider community remained largely uninvolved. The health unions and the normally active Community Health Council were effectively elminated by injunctions forcing them to dissociate themselves from the occupation. Remembering the fate of the miners, the unions were not prepared to risk losing £250,000 and when the crunch came they stepped aside. Five prominent campaigners, who were named in the injunctions, now fear the health authority might try to recover court costs of over £10 000 from them.

The downfall of the occupation is not the end of the story. It is merely one chapter in a sad tale of closures and cuts in Brent over the past decade.

Moreover, the closure of Neasden is not yet assured although the health authority has, by a casting vote, decided *in principle* to transfer patients to nearby hospitals and sell the six-acre site, valued at £2.7 million. Eventually it intends to care for the elderly in local resource centres though the finance for such a scheme has not been guaranteed.

Despite the anger and divisions, Vera Mitchell of Brent Health Emergency maintains the occupation did some good. 'Health is something people do not normally take a stand on. The publicity this has received has helped push the plight of Brent's health service towards the top of the agenda.'

Neasden is one of five hospital occupations in the capital in the past two years. Hayes Cottage and Northwood and Pinner won a reprieve, more recently, however, St Leonard's and South London Women's Hospital were ill fated.

Kevin Slack, coordinator of London Health Emergency, believes occupation has generally proved to be an effective strategy. 'But there has to be enough support within the hospital and among workers in the district. Health authorities must be dissuaded from seeking a court injunction by a firm threat to strike.

'Provided the solidarity is there, occupation is the best tactic against closure,' he said. (Danny Weiner)

City Limits
10-16 JAN 1986

DESPITE the legal injunction and strong-arm tactics used by Brent Health Authority to smash the recent occupation, Neasden Hospital is still open and caring for almost 80 patients.

But District health chiefs are still hoping to close the popular hospital in March this year as part of their heavy programme of cutbacks.

The closure decision was forced through the health authority last October on the casting vote of the government-appointed chairman Ivor Kingston and in the teeth of opposition from the local CHC, and from staff, relatives and campaigners who lent their support to the occupation which followed.

Though a sudden court injunction produced a wilting of official union support and meant that the occupiers lost the battle, the DHA has not yet won the war: indeed they do not yet have the necessary beds to transfer out the patients from Neasden and close it.

Staff and supporters are continuing the fight to save the hospital, arguing strongly in defence of its high standards of care for the elderly patients. RCN officer Rosie Young has said that:

The standards of nursing care at Neasden are excellent. I am very worried that any transfer of facilities may mean a lowering of standards."

Experience from previous closures of geriatric hospitals shows a big increase in mortality rates after patients suffer the trauma of being uprooted and moved against their will.

The campaign to save Neasden is being supported by NUPE and COHSE as well as Brent Health Emergency and local community organisations.

contribute
CONTRIBUTE
contribute!

All contributions welcome.
Please try to be brief. Please type if possible. Graphics must be in black ink.
Enclose your name, address and phone number. We will try to edit only in consultation.
Send to:

ASYLUM
c/o 19 Edgeware Road
YORK
YO1 4DG

Dear friends,

Thankyou very much for THE SHEFFIELD ANARCHIST. I'd be very pleased to keep on getting it, and I'll try to write something for it sometime. Generally the political mail censorship here has eased up somewhat, though there are still 5 pieces of mail which are witheld from me pending my appeal to the Mental Health Act commission, a proccess which takes months. Members of Liverpool DAM (Anarcho-Syndicalist group) have been able to visit me again, after being interviewed by my psychiatrist.

At the moment I'm busy trying to get released. My crime, which was not political, would probably have got me a fine or probation if I had not been diagnosed mentally ill. Once detained in this sort of place it's pretty difficult to get out if you are in any way radical. For instance some psychiatrists from an ordinary (i.e. not maximum security) mental hospital interviewed me with regard to being moved there. I was asked about my politics and espounded my pacifist-anarchist beliefs. The psychiatrists later told someone in authority here that they could not accept me because I had "sadistic political fantasies"! The only other way out of here is via a tribunal which can give you a conditional discharge. Unfortunately the tribunals are presided over by judges, so I'll probably have to wait until judges get to like anarchists before I'm released. But I'll keep trying.

Yours
Michael Davies

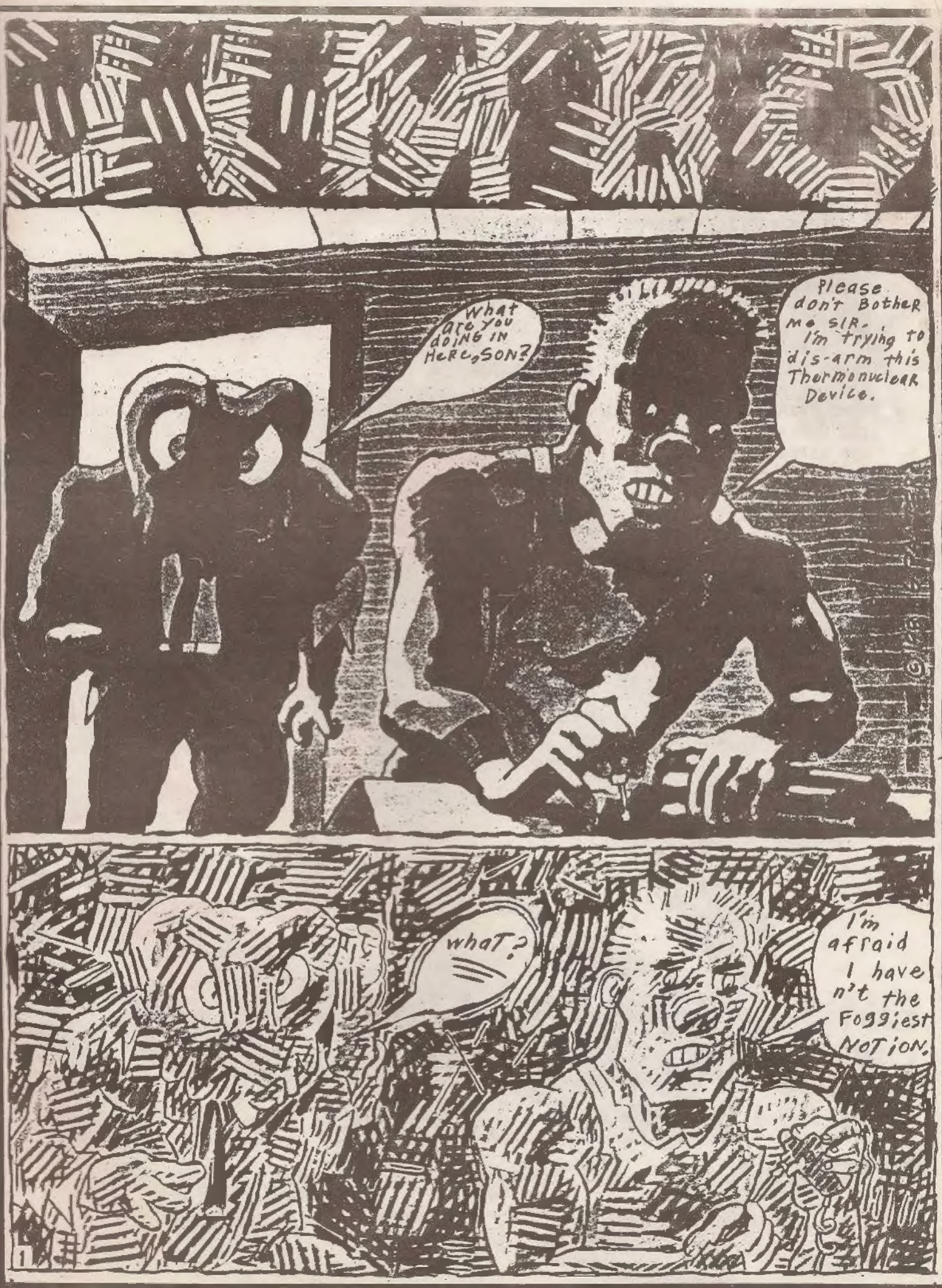
Please send messages of support to:

Michael Davies,
Eliot Ward,
Park Lane Hospital,
Maghull Lane,
Maghull,
Liverpool,
L31 1HW.

FROM: 'The Sheffield Anarchist'

HOSPITAL WORKERS'
NATIONAL ACTION COMMITTEE
organising rank and file action against health service cuts ...
NEXT MEETING IN YORK ON SAT. MAY 17th
for details contact Barbara Kearney tel. 0904 28723

Finally, back to the real, sane, normal world of what is it now? 30 tons equivalent of TNT in nuclear warheads for every man, woman & child on earth, poised as 'deterrent' for 'our defence'...Here's one for CND: from: JIMBO by Gary Panter, Raw Books, 1982, NYC.



Will Smoggo & Jimbo unilaterally disarm? Don't miss the next issue!

Asylum